



Complete Summary

GUIDELINE TITLE

Screening for asymptomatic bacteriuria: recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for asymptomatic bacteriuria: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 Feb. 5 p. [4 references]

COMPLETE SUMMARY CONTENT

SCOPE
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SCOPE

DISEASE/CONDITION(S)

Asymptomatic bacteriuria

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine
Urology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations on screening for asymptomatic bacteriuria and the supporting scientific evidence
- To update the 1996 recommendations contained in the Guide to Clinical Preventive Services, Second Edition

TARGET POPULATION

Adults at risk for asymptomatic bacteriuria

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for asymptomatic bacteriuria using urine culture and an enzymatic urine-screening test (Uriscreen™)

MAJOR OUTCOMES CONSIDERED

Key Question 1: Is there new direct evidence that screening for asymptomatic bacteriuria reduces morbidity or mortality?

Key Question 2: Is there new evidence that tests other than urine culture are more accurate than urine culture, and less expensive or more convenient for screening pregnant women for asymptomatic bacteriuria?

Key Question 3: Does treatment of asymptomatic bacteriuria improve health outcomes for those diagnosed by screening?

For pregnant women only (Key Questions 4-7):

Key Question 4: What are the harms of screening?

Key Questions 5 and 7: What are the costs of screening? What are the costs of treatment?

Key Question 6: What are the harms of treatment?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The search strategy for this brief update included a review of English-language articles published between 1994 and 2002 on new direct evidence of the benefits, harms, and costs of screening and treating asymptomatic bacteriuria. The literature search yielded 271 articles. We used the references for these articles to identify pertinent trials relevant to key questions. We also searched the Cochrane Library, The National Guideline Clearinghouse™, and PreMedline®. We searched for reviews, editorials, guidelines, commentaries, and Abridged Index Medicus journals focusing on screening for asymptomatic bacteriuria.

Among the articles identified, there was 1 study on a new screening test, 4 studies (2 based on a randomized controlled trial [RCT]) on the health outcomes of treating asymptomatic bacteriuria in pregnant and in elderly women, and 1 cost-benefit analysis of screening and treatment during pregnancy to prevent pyelonephritis. The MEDLINE® database was searched using "bacteriuria" as an exploded Medical Subject Heading® (MeSH®) term and "asymptomatic bacteriuria" as a text word, combining terms for "bacteriuria" separately with various other terms (e.g., "RCT," "meta-analysis," "mass screening").

NUMBER OF SOURCE DOCUMENTS

Key Question 1 = 0 studies
Key Question 2 = 0 studies
Key Question 3 = 5 studies

For pregnant women only (Key Questions 4-7):

Key Question 4 = 0 studies
Key Questions 5 and 7 = 1 study
Key Question 6 = 0 studies

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual

studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to "balance sheets") are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive service affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general

confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive at a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make a trade-off of benefits and harms a "close-call," then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr; 20(3S): 21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

COST ANALYSIS

One study conducted a cost-effectiveness and cost-benefit analysis on screening and treating pregnant women for asymptomatic bacteriuria to prevent pyelonephritis. A decision analytic model compared 2 screening strategies to detect asymptomatic bacteriuria during pregnancy – leukocyte esterase dipstick and urine culture. Sensitivity analyses were performed over a wide range of probabilities and cost estimates. Under baseline assumptions, no screening resulted in 23.2 cases of pyelonephritis per 1,000 pregnancies, versus 16.2 cases in those screened with the dipstick and 11.2 cases in those screened with urine culture. The cost of screening and treating 1,000 pregnant women for asymptomatic bacteriuria was \$1,968 with the dipstick and \$19,264 with urine culture. The cost of treating pyelonephritis in the absence of screening was \$57,562; the cost of treatment was \$40,257 when the dipstick was used to screen and \$27,832 when urine culture was used. Screening and treatment based on dipstick analysis prevented 7 cases of pyelonephritis per 1,000 pregnancies, at a cost of \$279 per case prevented. Screening with urine culture prevented 12 cases per 1,000 pregnancies at a cost of \$1,605 per case prevented. The incremental cost of each additional case of pyelonephritis prevented by screening with urine culture but not prevented by screening with dipstick was \$3,492. Other possible benefits of screening for asymptomatic bacteriuria in pregnant women, like a reduction of preterm deliveries, were not considered in this analysis.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the

Evidence-based Practice Center (EPC) and the Agency for Healthcare Research and Quality (AHRQ) send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations, and federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations regarding screening for asymptomatic bacteriuria were considered from the following groups: the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the Canadian Task Force on Preventive Health Care (CTFPHC).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF strongly recommends that all pregnant women be screened for asymptomatic bacteriuria using urine culture at 12 to 16 weeks' gestation. A Recommendation.

The USPSTF found good evidence that screening pregnant women for asymptomatic bacteriuria with urine culture significantly reduces symptomatic urinary tract infections, low birth weight, and preterm delivery. The benefits of screening and treatment substantially outweigh any potential harms.

The USPSTF recommends against the routine screening of men and nonpregnant women for asymptomatic bacteriuria. D Recommendation.

The USPSTF found fair evidence that screening men and nonpregnant women for asymptomatic bacteriuria is ineffective in improving clinical outcomes. In the absence of evidence of benefit, the potential harms associated with overuse of antibiotics are especially significant.

Clinical Considerations

- The screening tests used commonly in the primary care setting (dipstick analysis and direct microscopy) have poor positive and negative predictive

value for detecting bacteriuria in asymptomatic persons. Urine culture is the gold standard for detecting asymptomatic bacteriuria but is expensive for routine screening in populations with a low prevalence of this condition. Results from one study done with a new enzymatic urine-screening test (Uriscreen™) showed that the test has a sensitivity of 100 percent and a specificity of 81 percent.

- Good evidence exists that screening pregnant women for asymptomatic bacteriuria with urine culture (rather than urinalysis) significantly reduces symptomatic urinary tract infections, low birth weight, and preterm delivery. A specimen obtained at 12 to 16 weeks' gestation will detect approximately 80 percent of patients with asymptomatic bacteriuria. The optimal frequency of subsequent urine testing during pregnancy is uncertain.
- Good evidence exists that screening individuals other than pregnant women for asymptomatic bacteriuria does not significantly improve clinical outcomes. Results from a study of women with diabetes who were treated for asymptomatic bacteriuria demonstrated no reduction in complications. Although there were short-term results in clearing bacteriuria with antimicrobial therapy, there was no decrease in the number of symptomatic episodes or hospitalizations over the long term. Furthermore, the high rate of recurrence of bacteriuria in those who were screened and treated resulted in a marked increase in the use of antimicrobial agents.

Definitions:

Strength of Recommendations

The USPSTF grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Strength of Evidence

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Efficacy of Urine Culture

Good evidence exists that screening pregnant women for asymptomatic bacteriuria with urine culture (rather than urinalysis) significantly reduces symptomatic urinary tract infections, low birth weight, and preterm delivery. A specimen obtained at 12 to 16 weeks' gestation will detect approximately 80 percent of patients with asymptomatic bacteriuria. The optimal frequency of subsequent urine testing during pregnancy is uncertain.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They should not be construed as an official position of Agency for Healthcare Research and Quality (AHRQ) or the U.S. Department of Health and Human Services.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force equips it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive

Services Task Force reports. The U.S. Preventive Services Task Force convened representatives from the various audiences for the [Guide](#) ("Put Prevention Into Practice. A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach")--clinicians, consumers and policy makers from health plans, national organizations and Congressional staff--about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force and Community Guide effort have conducted an audience analysis to further explore implementation needs. The [Put Prevention into Practice](#) initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its [Web site](#). The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

RELATED QUALITY TOOLS

- [Pocket Guide to Good Health for Adults](#)
- [A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach](#)

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for asymptomatic bacteriuria: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 Feb. 5 p. [4 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2004 Feb 24)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members*: Alfred O. Berg, MD, MPH, Chair, USPSTF (Professor and Chair, Department of Family Medicine, University of Washington, Seattle, WA); Janet D. Allan, PhD, RN, CS, Vice-chair, USPSTF (Dean, School of Nursing, University of Maryland Baltimore, Baltimore, MD); Ned Calonge, MD, MPH (Acting Chief Medical Officer, Colorado Department of Public Health and Environment, Denver, CO); Paul Frame, MD (Tri-County Family Medicine, Cohocton, NY, and Clinical Professor of Family Medicine, University of Rochester, Rochester, NY); Joxel Garcia, MD, MBA (Deputy Director, Pan American Health Organization, Washington, DC); Russell Harris, MD, MPH (Associate Professor of Medicine, Sheps Center for Health Services Research, University of North Carolina School of Medicine, Chapel Hill, NC); Mark S. Johnson, MD, MPH (Professor of Family Medicine, University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark, NJ); Jonathan D. Klein, MD, MPH (Associate Professor, Department of Pediatrics, University of Rochester School of Medicine, Rochester, NY); Carol Loveland-Cherry, PhD, RN (Executive Associate Dean, School of Nursing, University of Michigan, Ann Arbor, MI); Virginia A. Moyer, MD, MPH (Professor, Department of Pediatrics, University of Texas at Houston, Houston, TX); C. Tracy Orleans, PhD (Senior Scientist, The Robert Wood Johnson Foundation, Princeton, NJ); Albert L. Siu, MD, MSPH (Professor of Medicine, Chief of Division of General Internal Medicine, Mount Sinai School of Medicine, New York, NY); Steven M. Teutsch, MD, MPH (Senior Director, Outcomes Research and Management, Merck & Company, Inc., West Point, PA); Carolyn Westhoff, MD, MSc (Professor of Obstetrics and Gynecology and Professor of Public Health, Columbia University, New York, NY); and Steven H. Woolf, MD, MPH (Professor, Department of Family Practice and Department of Preventive and Community Medicine and Director of Research Department of Family Practice, Virginia Commonwealth University, Fairfax, VA)

*Member of the USPSTF at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force (USPSTF) has an explicit policy concerning conflict of interest. All members and Evidence-based Practice Center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 31, Screening for asymptomatic bacteriuria. p. 347-59.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Screening for asymptomatic bacteriuria: a brief evidence update for the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2004 Feb. 5 p.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr; 20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr; 20(3S): 21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr; 20(3S): 36-43.

Electronic copies: Available from [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

The following is also available:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the [AHRQ Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

PATIENT RESOURCES

The following is available:

- The pocket guide to good health for adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Copies also available in Spanish from the [USPSTF Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on April 8, 2004. The updated information was verified by the guideline developer on April 22, 2004.

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